marrow transplantation in first remission for patients younger than 40 years who have acute myelogenous leukemia, autologous bone marrow transplantation for patients between the ages of 40 and 55 with acute myelogenous leukemia or for those younger than age 40 without a matched donor, allogeneic marrow transplantation for patients younger than 50 years with chronic myelogenous leukemia in the chronic phase and allogeneic transplantation for patients younger than 40 years with relapsed acute lymphoblastic leukemia.

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REFERENCES

Applebaum FR, Dahlberg S, Thomas ED, et al: Bone marrow transplantation or chemotherapy after remission induction for adults with acute nonlymphoblastic leukemia. Ann Intern Med 1984; 101:581-588

Pirsch JD, Maki DG: Infectious complications in adults with bone marrow transplantation and T-cell depletion of donor marrow. Ann Intern Med 1986; 104:619-631

Thomas ED, Clift RA, Fefer A, et al: Marrow transplantation for the treatment of chronic myelogenous leukemia. Ann Intern Med 1986; 104:155-163

Thomas ED: Marrow transplantation for malignant diseases. J Clin Oncol 1983; 1:517-531

Yeager AM, Kaiser H, Santos GW, et al: Autologous bone marrow transplantation in patients with acute nonlymphocytic leukemia, using ex vivo marrow treatment with 4-hydroperoxycyclophosphamide. N Engl J Med 1986; 315:141-147

Physician-Patient Communication

RECENT SOCIAL SCIENTIFIC RESEARCH has clarified certain social structural barriers to physician-patient communication. Practicing internists spend little time giving information to their patients (about 1.3 minutes on the average in encounters lasting about 20 minutes), overestimate the time they spend giving information (by a factor of about nine) and underestimate their patients' desire for information. College-educated patients and those with upper- or upper-middle-class occupations generally receive more information than do patients who have not gone to college or who hold working-class occupations. There is no difference between poorly educated, lower-class patients and better educated, upper-class patients in their desire for information. Physicians, however, misperceive this desire much more commonly for poorly educated or lower-class patients. Busier internists who see more than 20 patients per day spend much less time giving information and also give a smaller number of explanations. Because adequate communication takes time, this finding has implications about the number of patients whom physicians should reasonably see per day in clinical practice.

Another fruitful direction of research has focused on nonverbal communication and the sociolinguistic structure of physician-patient encounters. When physicians are skillful at decoding body movement and postural cues to emotion (as measured by tests of nonverbal communication ability), their patients show higher levels of satisfaction and compliance. Interestingly, physicians' expression of nonverbal tension in encounters is positively associated with patients' satisfaction and compliance, probably because it conveys a strong task orientation to which patients respond favorably. Physicians frequently interrupt patients during encounters; usually these interruptions involve physician-initiated questions. Such a "high-control style" may have counterproductive effects in history taking, especially when it leads physicians to overlook nontechnical concerns that patients feel are important in their everyday lives. Interrupting behavior also may reflect sexual differences in language use, because female physicians tend to interrupt their patients much less frequently than do male physicians.

Training programs should emphasize the potentialities for improving physician-patient communication. In particular, physicians should know that patients frequently want more information than practitioners realize and that sociolinguistic differences in language use can impede effective communication. Nonverbal communication skills and the highly structured, interrogative mode of the medical history also deserve reconsideration in medical education.

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REFERENCES

Beckman HB, Frankel RM: The effect of physician behavior on the collection of data. Ann Intern Med 1984 Nov; 101:692-696

Mishler EG: The Discourse of Medicine: Dialectics of Medical Interviews. Norwood, NJ, Ablex Publ, 1984

Waitzkin H: Doctor-patient communication: Clinical implications of social scientific research. JAMA 1984 Nov; 252-2441-2446

Waitzkin H: Information giving and medical care. J Health Soc Behav 1985 Jun; 26:81-101

West C: Routine Complications: Troubles With Talk Between Doctors and Patients. Bloomington, Ind, Indiana University Press, 1984